Patient Summary

Patient Name	
Patient DOB	
Mother's Phone Number	
Father's Phone Number	
Mother's email	
Father's email	
Child's Grade	
School Name	
Emergency Contact Name	
Emergency Phone Number	

If parents are divorced, who has custody? ____

If parents are divorced, where does the other parent live? ____

Who referred patient to BH Clinic? ____

Is child enrolled in EFMP? Yes No

Learning Needs Assessment

Preferred Spoken Language: ____________________________

Preferred Written Language: ____________________________

Preferred Mode of Communication: (pick one)

	Verbal
	Sign Language
	Written
	Assistive Technology
	Communication Device

Preferred Method of Learning: (select all that apply)

	Demonstration
	Printed Materials
	Verbal Explanation
	Video/Educational TV
	Internet
	Other:

Preferred Method of Communication: (pick one)

	No Preference
	Printed Letter
	Phone Call
	Patient Portal
	Secure Email

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

	Never
	Rarely
	Sometimes
	Often
	Always

Cultural/Religious Beliefs that May Affect Care: [ ] Yes [ ] No [ ] Decline to answer. If yes, please explain:

____

____

____

Are there any Barriers to Learning: [ ] Yes [ ] No [ ] Decline to answer. If yes, please explain:

____

____

____

Pain

DVPRS Pain Scale

	0	No pain
	1	Hardly notice pain
	2	Notice pain, does not interfere with activities
	3	Sometimes distracts me
	4	Distracts me, can do usual activities
	5	Interrupts some activities
	6	Hard to ignore, avoid usual activities
	7	Focus of attention, prevents doing daily activities
	8	Awful, hard to do anything
	9	Can't bear the pain, unable to do anything
	10	As bad as it could be, nothing else matters

Primary pain location: ____________________________

Pain follow-up

	Pain is being addressed
	Patient agrees to seek medical care
	Other:

Safety

	Yes	No
Does child have any history of being abused		
Child afraid of anyone in home		
Child afraid of anyone at school		
Child witnessed violence in home		
Child aggressive toward anyone		
Family history of CPS report		
Threats of suicide		
Threats of homicide		
Gun present at home		

Supplements

Do you take home dietary supplements: [ ] Yes [ ] No If yes, please list:
____
____
____

Nutritional Screen

Does child have any of the following:

	None
	A food allergy that inhibits adequate nutritional intake
	Chewing or swallowing problems that inhibit adequate nutritional intake
	Eating habits or behaviors that may be indicators of an eating disorder

Does child have any concerns with your teeth that make it difficult to eat? [ ] Yes [ ] No

Does child regularly overeat to the point of feeling sick or making himself/herself vomit from eating too much? [ ] Yes [ ] No

Has child gained or lost 10 pounds in the past 3 months without trying? [ ] Yes [ ] No

Has child been eating 1/2 of what he/she normally eats because of a decreased appetite? [ ] Yes [ ] No

Does child have any food allergies, intolerance, special dietary needs, or ethnic, cultural or religious preferences affecting your dietary needs? [ ] Yes [ ] No